BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **Michael P. Ridge, M.D.** License No. 15513 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-09-1154A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO THE SAME CONSENT**

Michael P. Ridge, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 15513 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-1154A after receiving a complaint regarding Respondent's care and treatment of a 20 year-old male patient ("CG") alleging inappropriate prescribing of controlled medications to a patient with suicidal tendencies and multiple overdoses.

4. Respondent began treating CG in March of 2006. Respondent documented GI complaints and that CG was craving opioids that had not been adequately controlled. The assessment included gastroenteritis, backache, muscle spasm and depression. Respondent's records indicated that he prescribed Levsin SL, Phenergan, and Prozac. CG also filled prescriptions written by Respondent for Lorazepam and Vicodin that were not recorded in the chart.

5. In February 2007, Respondent documented that he received notice from a pharmacy that CG was receiving controlled substances from other providers. CG was dismissed from the practice and a certified letter was sent to that effect. CG subsequently sent a letter to Respondent reporting that there had been a misunderstanding with the two pharmacies and requested that Respondent reconsider his decision to dismiss CG from the practice. The practice dismissal was withdrawn on February 20th, 2007.

6. On March 28, 2007, Respondent resumed writing prescriptions for Xanax, Clonazepam and Paxil. On April 7, 2007, CG underwent a psychiatric evaluation that listed diagnoses of anxiolytic abuse and opioid dependence, and reported that CG was receiving medications from three different physicians.

7. On January 12, 2008, CG's mother reported that CG had attempted suicide and the covering provider advised that CG obtain an ER evaluation. CG did not obtain the evaluation and refilled his Clonazepam prescription on January 31, 2008.

8. On February 4, 2008, Respondent saw CG and authorized Lorazepam. CG was again treated on February 6, 2008, for sinusitis, pharyngitis, insomnia and depression. Medications prescribed included Lorazepam, Clonazepam and Seroquel. On August 8, 2008, CG was seen for a check-up and was noted to be going into drug treatment.

9. Respondent did not see CG again until August 4, 2009 and the assessment included Generalized Anxiety Disorder. Respondent prescribed Clonazepam to CG; however, there was no documentation regarding CG's drug treatment, Respondent did not request records and no urine drug testing was done. Respondent saw CG several more times and continued to prescribe narcotics in spite of three documented suicide attempts and frequent early refills of his medications.

10. The standard of care requires a physician to perform an evaluation of the patient's pain problem prior to prescribing narcotics; to obtain random urine drug testing in

a patient that reports problems with opioid abuse and be aware of red flags indicating medication misuse; to discontinue prescribing anxiolytics and opioids when the patient is found to be obtaining scheduled medications from multiple providers and has a psychiatry consultation report demonstrating the patient is addicted to the medication; to avoid prescribing multiple different anxiolytic agents concomitantly; to address reports from family members of a possible suicide attempt and obtain medical records regarding the incident; and to obtain medical records and prescription information on a patient who had last been seen just prior to entering a rehabilitation program before prescribing further Clonazepam.

11. Respondent deviated from the standard of care because he prescribed narcotics for chronic pain without performing an evaluation of the pain problem; he failed to obtain random urine drug testing in a patient who reported problems with opioid abuse and continued to provide scheduled medications in spite of red flags indicating medications misuse; he continued to prescribe anxiolytic medications to CG after undergoing a psychiatric evaluation that reported he was addicted to opioids and anxiolytics and was receiving scheduled medications from multiple providers; he prescribed multiple different anxiolytic agents concomitantly; he failed to address family reported concerns regarding a suicide attempt with the patient or obtain medical records regarding the incident; and he prescribed Clonazepam with refills to a patient who was last evaluated one year previously just prior to entering a rehabilitation program, without obtaining medical records and a pharmacy profile on the patient.

12. Respondent potentially delayed CG from obtaining effective treatment for his anxiety by providing numerous anxiolytic agents. Respondent also potentially contributed to a delay in the treatment of CG's opioid and anxiolytic addictions. CG was at increased risk for overdose on the multiple anxiolytic medications prescribed by Respondent.

13. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. §32-1401(2). Respondent's medical records were inadequate because his progress notes contained limited specific documentation regarding the history of present illness, did not address reports of hospitalization or suicide attempts, and often failed to document prescribed medications and exams.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Continuing Medical Education

Respondent shall complete the PACE prescribing course within six months of the effective date of this Order. Upon completion of the course, Respondent shall provide Board Staff with satisfactory proof of attendance. The CME course hours shall be in addition to the CME hours required for the biennial renewal of medical license.

DATED AND EFFECTIVE this 10th day of June, 2010.

ARIZONA MEDICAL BOARD

(SEAL)

By _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any

modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

_____ DATED: 5-12-10
MICHAEL P. RIDGE, M.D.

EXECUTED COPY of the foregoing mailed this 10th day of June, 2010 to:

Michael P. Ridge, M.D.
Address of Record

ORIGINAL of the foregoing filed this 10th day of June, 2010 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

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Arizona Medical Board Staff